(3) SE1: requires one extensive service;

(4) RAD: requires rehabilitation services and is dependent in activity of daily living (ADL) at a count of 17 or 18;

(5) RAC: requires rehabilitation services and ADL count is 14 to 16;

(6) RAB: requires rehabilitation services and ADL count is ten to 13;

(7) RAA: requires rehabilitation services and ADL count is four to nine;

(8) SSC: requires special care and ADL count is 17 or 18;

(9) SSB: requires special care and ADL count is 15 or 16;

(10) SSA: requires special care and ADL count is seven to 14;

(11) CC2: clinically complex with depression and ADL count is 17 or 18;

(12) CC1: clinically complex with no depression and ADL count is 17 or 18;

(13) CB2: clinically complex with depression and ADL count is 12 to 16;

(14) CB1: clinically complex with no depression and ADL count is 12 to 16;

(15) CA2: clinically complex with depression and ADL count is four to 11;

(16) CA1: clinically complex with no depression and ADL count is four to 11;

(17) IB2: impaired cognition with nursing rehabilitation and ADL count is six to ten;

(18) IB1: impaired cognition with no nursing rehabilitation and ADL count is six to ten;

(19) IA2: impaired cognition with nursing rehabilitation and ADL count is four or five;

(20) IA1: impaired cognition with no nursing rehabilitation and ADL count is four or five;

(21) BB2: behavior problems with nursing rehabilitation and ADL count is six to ten;

(22) BB1: behavior problems with no nursing rehabilitation and ADL count is six to ten;

(23) BA2: behavior problems with nursing rehabilitation and ADL count is four to five;

(24) BA1: behavior problems with no nursing rehabilitation and ADL count is four to five;

(25) PE2: reduced physical functioning with nursing rehabilitation and ADL count is 16 to 18;

(26) PE1: reduced physical functioning with no nursing rehabilitation and ADL count is 16 to 18;

(27) PD2: reduced physical functioning with nursing rehabilitation and ADL count is 11 to 15;

(28) PD1: reduced physical functioning with no nursing rehabilitation and ADL count is 11 to 15;

(29) PC2: reduced physical functioning with nursing rehabilitation and ADL count is nine or ten;

(30) PC1: reduced physical functioning with no nursing rehabilitation and ADL count is nine or ten;

(31) PB2: reduced physical functioning with nursing rehabilitation and ADL count is six to eight;

(32) PB1: reduced physical functioning with no nursing rehabilitation and ADL count is six to eight;

(33) PA2: reduced physical functioning with nursing rehabilitation and ADL count is four or five; and

(34) PA1: reduced physical functioning with no nursing rehabilitation and ADL count is four or five.

SECTION 14.020 **Class weights.** The Department assigns a case mix index to each resident class based on the Centers for Medicare & Medicaid Services' staff time measurement study, adjusted for Minnesota-specific wage indices. An index maximization approach is used to classify residents. Residents are classified into the class for which they qualify that has the highest case mix value.

A. The Department assigns case mix indices to each resident class according to subitems (1) to (34).

(1) Class SE3, 2.02;

(2) Class SE2, 1.71;

(3) Class SE1, 1.51;

(4) Class RAD, 1.62;

(5) Class RAC, 1.28;

(6) Class RAB, 1.20;

(7) Class RAA, 1.04;

(8) Class SSC, 1.40;

(9) Class SSB, 1.32;

(10) Class SSA, 1.23;

(11) Class CC2, 1.49;

(12) Class CC1, 1.25;

(13) Class CB2, 1.14;

(14) Class CB1, 1.04;

(15) Class CA2, 1.04;

(16) Class CA1, 0.92;

(17) Class IB2, 0.85;

(18) Class IB1, 0.74;

(19) Class IA2, 0.69;

(20) Class IA1, 0.53;

(21) Class BB2, 0.73;

(22) Class BB1, 0.69;

(23) Class BA2, 0.61;

(24) Class BA1, 0.59;

(25) Class PE2, 1.00;

(26) Class PE1, 0.98;

(27) Class PD2, 0.85;

(28) Class PD1, 0.84;

(29) Class PC2, 0.84;

(30) Class PC1, 0.84;

(31) Class PB2, 0.63;

(32) Class PB1, 0.63;

(33) Class PA2, 0.60;

(34) Class PA1, 0.59.

B. After implementation of the RUG-III case mix system, the Department may annually rebase case mix indices and base rates using more current data on average wage rates and staff time measurement studies. This rebasing will be calculated in a facility-specific budget neutral manner as described in Section 14.040.

SECTION 14.030 **Resident assessment schedule.** Nursing facilities must conduct and electronically submit to the Department of Health case mix assessments that conform to the assessment schedule defined in Code of Federal Regulations, title 42, section 483.20, and published by the Centers for Medicare & Medicaid Services in the Long Term Care Assessment Instrument User's Manual, version 2.0 (October 1995), and subsequent clarifications made in the Long-Term Care Assessment Instrument Questions and Answers, version 2.0, August 1996. The Department of Health may substitute successor Centers for Medicare & Medicaid Services' manuals or question and answer documents to replace or supplement the current version of the manual or document.

A. The case mix assessments used for Minnesota's case mix classifications are:

(1) New admission assessments, which must be completed by day 14 following admission;

(2) Annual assessments, which must be completed within 366 days of the last comprehensive assessment;

(3) Significant change assessments, which must be completed within 14 days of the identification of a significant change; and

(4) Second quarterly assessments, which must be completed following new admission assessments, annual assessments, and significant change assessments (if significant change assessments have been made). Each quarterly assessment must be completed within 92 days of the previous assessment.

B. (1) A facility must submit to the Department of Health an initial admission assessment for all residents who stay in the facility less than 14 days.

(2) Notwithstanding subitem (1), in lieu of submitting an initial admission assessment, a facility may elect to accept a default rate with a case mix index of 1.0 for all facility residents who stay less than 14 days. Residents with a stay of less than 14 days who are admitted to a nursing facility that makes this election for all stays of less than 14 days will be assigned a RUG case mix classification code of DDF.

(3) Nursing facilities must elect one of the options in subitems (1) and (2) with the Department of Health on an annual basis. The election will be effective on the following July 1.

C. Residents who are admitted and readmitted and leave the facility on a frequent basis and for whom readmission is expected may be discharged on an extended leave status. This status does not require reassessment each time the resident returns to the facility unless a significant change in the resident's status has occurred since the last assessment. The case mix classification for these residents is determined by the facility election made in item B.

D. A facility that fails to complete or submit an assessment for a RUG-III classification within seven days of the time requirements according to the schedule in item A is subject to a reduced rate for that resident. The resident for whom the facility failed to complete or submit an assessment within the time required will be assigned a RUG case mix classification code BC1. The reduced rate is the lowest rate for that facility. The reduced rate is effective on the day of admission for new admission assessments or on the day that the assessment was due for all other assessments and continues in effect until the first day of the month following the date of submission of the resident's assessment.

E. Resident reimbursement classifications will be effective:

(1) The day of admission for new admission assessments.

(2) The assessment reference date, which is the last day of the MDS observation period, for significant change assessments.

(3) The first day of the month following the assessment reference date for annual and second quarterly assessments.

SECTION 14.040 **Rate determination upon transition to RUG-III payment rates.** The Department determines payment rates at the time of transition to the RUG-III model in a facility-specific, budget-neutral manner in accordance with items A through C.

A. The case mix indices as defined in Section 14.020, item A are used to allocate the case mix adjusted component of total payment across all case mix groups. To transition from the current calculation methodology to the RUG-III model, the Department of Health reports to the Department of Human Services the resident days classified according to the categories defined in Section 14.010, item B for the 12-month reporting period ending September 30, 2001 for each nursing facility. The Department uses this data to compute the standardized days for the reporting period under the RUG-III system.

B. The Department determines the case mix adjusted component of the rate following the steps in to subitems (1) through (6):

(1) determine the case mix portion of the 11 case mix rates in effect on June 30, 2002 plus any rate adjustments that are effective on or after July 1, 2002.

(2) multiply each amount in subitem (1) by the number of resident days assigned to each group for the reporting period ending September 30, 2001.

(3) compute the sum of the amounts in subitem (2).

(4) determine the total RUG standardized days for the reporting period ending September 30, 2001.

(5) divide the amount in subitem (3) by the amount in subitem (4), which is the average case mix adjusted component of the rate under the RUG-III method.

(6) multiply the result of subitem (5) by the case mix weight in Section 14.020, item A for each RUG group.

(C) The non-case mix component is allocated to each RUG group as a constant amount to determine the transition payment rate to be effective October 1, 2002.

SECTION 15.000 RESIDENT ASSESSMENT

SECTION 15.010 **Assessment of nursing facility applicants and newly admitted residents.** Each nursing facility applicant or newly admitted resident must be assessed for the purpose of determining the applicant's or newly admitted resident's case mix class. ~~The assessment must be conducted according to the procedures in items A to J.~~

A. The county long-term care consultation team or hospital screening team under contract with the county must assess all nursing facility applicants for whom preadmission screening is required and any applicant for whom a preadmission screening is not required but who voluntarily requests such a screening, ~~except as provided in subitems (1) and (2)~~.

~~(1) The public health nurse of the county long-term care consultation team or the registered nurse case manager shall assess a nursing facility applicant, if the applicant was previously screened by the county long-term care consultation team and the applicant is receiving services under the alternative care grants program or under the Medical Assistance Program.~~

B. ~~(2)~~ For an applicant whose admission to the nursing facility is for the purpose of receiving respite care services ~~need not be reassessed~~ , preadmission screening is not required more than once every six months ~~for the purpose of computing resident days under Section 9.020, if the applicant has been classified by the Department of Health within the prior six-month period. In this case, the resident class established by the Department of Health within the prior six-month period may be the resident class of the applicant. A resident must not receive more than one assessment per respite care stay.~~

~~B. The long-term care consultation team will recommend a case mix classification for applicants and newly admitted residents when sufficient information is received to make that classification.~~

~~C. Except as provided in item A, subitem 2, the nursing facility must assess each applicant or newly admitted resident for whom a preadmission screening is not required or is not requested voluntarily. For the purposes of this item, the term newly admitted resident includes a resident who moves to a section of the nursing facility that is licensed differently than the section the resident previously was placed in or a resident who has been transferred from another nursing facility.~~

~~D. Except as provided in item D, the assessment required by this subpart must be performed within ten working days before or ten working days after the date the applicant is admitted to the nursing facility.~~

~~E. Any resident who is required to be assessed by the long-term care consultation team under item A or who has received a prior preadmission screening, and for whom the assessment required under this subpart has not been performed by the long-term care consultation team within ten working days before or ten working days after the date the applicant is admitted to the nursing facility must be assessed by the nursing facility. The nursing facility must perform the assessment and submit the forms to the Department of Health within 15 working days after admission.~~

~~F. Each assessment that the nursing facility is required to perform must be completed by a registered nurse. The registered nurse performing the assessment must sign the assessment form.~~

~~G. The assessment of each applicant or newly admitted resident must be based on procedures of the Department of Health including physical observation of the applicant or newly admitted resident and review of available medical records, and must be recorded on the assessment form.~~

~~H. Within five working days following the assessment, the long-term care consultation team or hospital screening team under contract with the county must send the completed assessment form to the Department of Health, and provide a copy to the nursing facility.~~

~~I. Except as provided in item D, each assessment completed under items A to G and a completed medical plan of care must be submitted to the Department of Health by the nursing facility as a request for classification within ten working days after admission or after the assessment, whichever is later.~~

~~J. The resident class for applicants or newly admitted residents must be effective on the date of the person's admission to the nursing facility.~~

SECTION 15.020 ~~**Semiannual assessment by nursing facilities.** Semiannual assessments of residents by the nursing facility must be completed in accordance with items A to D.~~

~~A. A nursing facility must assess each of its residents no earlier than 162 days and no later than 182 days after the date of the most recent annual assessment by the Department of Health.~~

~~B. A registered nurse shall assess each resident according to procedures established by the Department of Health including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse performing the assessment shall sign the assessment~~

~~form.~~

~~C. Within five working days of the completion of the nursing facility's semiannual resident assessments, the nursing facility must forward to the Department of Health requests for classification for all residents assessed for the semiannual assessment. These requests must include the assessment forms, and the nursing facility's daily census for the date on which the assessments were completed including an explanation of any discrepancy between the daily census and the number of assessments submitted. The nursing facility must provide additional information to the Department of Health if the Department of Health requests the information in order to determine a resident's classification.~~

~~D. Any change in resident class due to a semiannual assessment must be effective on the first day of the month following the date of the completion of the semiannual assessments.~~

~~SECTION 15.030 **Change in classification due to annual assessment by Department of Health.** Any change in resident class due to an annual assessment by the Department of Health will be effective as of the first day of the month following the date of completion of the Department of Health's assessments.~~

~~SECTION 15.040 **Assessment upon return to the nursing facility from a hospital.** Residents returning to a nursing facility after hospitalization must be assessed according to items A to D.~~

~~A. A nursing facility must assess any resident who has returned to the same nursing facility after a hospital admission. The assessment must occur no more than five working days after the resident returns to the same nursing facility.~~

~~B. In addition to the assessment required in item A, residents who have returned to the same nursing facility after hospital admission must be reassessed by the nursing facility no less than 30 days and no more than 35 days after return from the hospital unless the nursing facility's annual or semiannual reassessment occurs during the specified time period.~~

~~C. A registered nurse shall perform the assessment on each resident according to procedures established by the Department of Health, including physical observation of the resident, review of the medical plan of care, and review of the resident's plan of care, and shall record the assessment on the assessment form. The registered nurse who performs the assessment shall sign the assessment form. Within five working days of the completion of the assessment, the nursing facility must forward to the Department of Health a request for a classification for any resident assessed upon return to the nursing facility after a hospital admission. This request must include the assessment form and the resident's medical plan of~~